PACT
A feasibility trial of Acceptance and Commitment Therapy for emotional recovery following psychosis

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Nothing fixes a thing so intensely in the memory as the wish to forget it
– Michel de Montaigne
Emotional Difficulties Following Psychosis

• Psychosis associated with appraisals of loss, entrapment and humiliation (Birchwood et al., 2000) and feelings of fear (Shaw et al., 1997; 2002).

• Emotional difficulties lead to psychosis – the experience of psychosis can lead to emotional difficulties.

• Rates of depression of 50% following a first episode of psychosis and 33% in established psychosis. (Whitehead et al., 2002)

• CBT for psychosis has limited effectiveness for treating depression following psychosis (Wykes et al., 2008) – particularly when methodological quality was controlled for.
First Person Perspective

“....I was trying to think how I could describe the last 23 years of medication, and eh, hospitalisation, and you know, subsequent lifestyles that I’ve become involved in and things like that, and I would have to say that basically it’s been 23 years of physical, psychological and sexual abuse, and it’s just going on and on and it never ends.”
Aims of the PACT trial

A *feasibility* study investigating:

a) The acceptability of Acceptance and Commitment Therapy to individuals with psychosis.

b) The appropriateness of primary and secondary outcomes for assessing distress associated with the experience of psychosis and relevant mechanisms of change.

c) Whether a larger scale multi-centre randomised controlled trial is warranted.
Participants

- 27 individuals with psychosis took part: 6 females (22%) and 21 males (78%).
- Mean age of participants = 34.04 years (range: 18-51).
- Recruited on the basis of being distressed by the experience of psychosis. Referred by NHS teams.
- Diagnosed with psychotic disorders. Recruited from community mental health teams, first episode services and medium secure forensic unit.
- Excluded if a score of 5 or above on individual items of the PANSS positive syndrome subscale.
Methodology

Design: The study was a single-blind (rater) pilot randomized controlled trial comparing *ACT plus treatment as usual* (TAU) compared to *TAU* alone:

- 14 people got ACT
- 13 people got their usual treatment

We compared changes in the two groups over a 3 month period: From randomisation to 3 months post-randomisation.
Intervention

• 10 sessions
• Kevin Polk’s matrix used for formulation
• A CD incorporating a mindfulness exercise for psychosis (Paul Chadwick) and two defusion exercises (mind room, bubble wand).
• Using an extended metaphor/allegory to run alongside the treatment: ‘See the wood for the trees’.
See The Wood for the Trees
(and other helpful advice for living life)

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Participants

Diagnoses:

- Schizophrenia (F20) 13
- Unspecified Non-organic Psychosis (F29) 7
- Schizo-affective Disorder Manic Type (F25.0) 1
- Schizo-affective Disorder Not Specified (F25.9) 2
- Bipolar Disorder Mania and psychosis (F31.2) 1
- Bipolar Disorder depression and psychosis (F31.5) 2
- Recurrent depressive disorder, current episode severe with psychotic symptoms (F33.3) 1
Measures

• Outcome measures:
  – Hospital Anxiety and Depression Scale
  – PANSS
  – Fear of Recurrence Scale
  – Self-ratings of positive symptoms (frequency, believability, distress)

• ACT-specific measures:
  – Acceptance and Action Questionnaire - II
  – Kentucky Inventory of Mindfulness Skills
  – Valued Living Questionnaire

• Therapeutic alliance:
  – Working Alliance Inventory (short–form revised)
Drop out from the study

\[(\chi^2 = 4.79, p < 0.05)\]
What service users thought of ACT

- The Working Alliance Inventory (Short Form Revised) measures *therapeutic alliance*.
- It assesses 3 aspects of the alliance:
  (a) agreement between client and therapist on the goals of therapy,
  (b) agreement between client and therapist on the tasks of therapy
  (c) the quality of the interpersonal bond between client and therapist.
What service users thought of ACT

<table>
<thead>
<tr>
<th>Service</th>
<th>Rating</th>
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</thead>
<tbody>
<tr>
<td>Goal</td>
<td>17.5</td>
</tr>
<tr>
<td>Task</td>
<td>15.8</td>
</tr>
<tr>
<td>Bond</td>
<td>17.2</td>
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</tbody>
</table>
Change in Depression Caseness (HADS depression subscale score ≥ 8)

\( \chi^2 = 4.67, p < 0.05 \)  
(effect size = 0.43)
Change in Depression

• In accordance with previous papers clinical change was defined as a decrease of ≥ 50% from baseline scores (Christodoulides, et al., 2008; Stojadinovic, et al., 2002).

• 75% of participants in the ACT group who were depressed at baseline achieved clinically significant decreases in levels of depression.

• None of the participants who received TAU and depressed at baseline achieved clinically significant decreases in levels of depression.
Change in Anxiety Caseness (HADS anxiety subscale score ≥ 8)

\[(\chi^2 = 1.01, p = 0.314)\] (effect size = 0.03)
Crisis Contacts

• The crisis service works with people who are experiencing increased distress in terms of their mental health and are at risk of admission to a psychiatric hospital.
Mean Number of Crisis Contacts

\[ Z = -2.24, \ p < 0.05 \]
Change in Positive Symptoms

(t = 0.24, df = 19, p = 0.81) (effect size = 0.05)
Change in Negative Symptoms

ACT

TAU

Baseline

3 Months

(t = -2.36, df = 19, p < 0.05)

(effect size = 0.47)
Changes in AAQ-II Scores

(t = 0.60, df = 21, p = 0.56) (effect size = 0.13)
Changes in Mindfulness Skills

(t = 2.66, df = 21, p < 0.05) (effect size = 0.50)
Processes of Change?

• The change in Depression scores for the ACT group had a significant correlation with the change in mindfulness skills ($\rho = -0.66$, $p < 0.05$)
Conclusions

• ACT was acceptable to people recovering from psychosis.
• ACT lead to a significant decrease in the number of people who were depressed compared to treatment as usual.
• Changes in depression were related to changes in mindfulness.
• Those getting ACT had significantly less contact with crisis services.
• ACT had a significant impact on negative symptoms relative to treatment as usual.